

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155329		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/05/2013	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT INDIANAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N LESLEY AVE INDIANAPOLIS, IN 46219			
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F0000	<p>This visit was for the Investigation of Complaint IN00123531.</p> <p>Complaint IN00123531-Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey Date: 2/5/2013</p> <p>Facility number: 000222 Provider number: 155329 AIM number: 100274950</p> <p>Survey Team: Courtney Mujic, RN- TC Beth Walsh, RN Karina Gates, Medical Surveyor</p> <p>Census Bed Type: SNF: 11 SNF/NF: 121 Total: 132</p> <p>Census Payor Type: Medicare: 51 Medicaid: 79 Other: 2 Total: 132</p> <p>Sample: 3</p>			F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after February 20, 2013.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 2/12/13 by Suzanne Williams, RN</p>						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to prevent a resident at risk for falls from falling during patient care for 1 of 1 resident reviewed for accidents in a sample of 3. (Resident A)</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 2/5/13 at 1:00 p.m. Resident A was admitted to the facility on 1/17/13 after a fall-related hospital stay.</p> <p>The diagnoses for Resident A included, but were not limited to: left side hemiplegia.</p> <p>The 1/11/13 preadmission Resident Assessment, provided by the DON (Director of Nursing) on 2/5/13 at 2:30 p.m., indicated, "Reason for Placement/Current Problems:</p>		F0323	<p>F323 What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The resident's incident was evaluated by the IDT team after the fall and appropriate interventions of scoop mattress and 2 person assist were put in place to prevent further occurrence. The resident obtained no injury related to the fall. The involved CNA was provided education on proper repositioning techniques while residents are in bed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents assessed to be at risk for falls have the potential to be affected by this alleged deficient practice. All CNAs will be re-educated on appropriate positioning and turning techniques, precautions to be taken with those residents with weakness related to CVAs, and complete a positioning skills validation by the SDC by 2/20/13. What measures will be put into</p>		02/20/2013	

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	<p>Previously indep. (independent) female who had fall at home resulting in large intracranial hemorrhage (symbol for "with") (symbol for "left") sided hemiplegia...unable to get out of bed w/out max (maximum) assist..."</p> <p>The 1/17/13 Admission Nursing Assessment, provided by the DON on 2/5/13 at 2:30 p.m., indicated Resident A used a wheel chair for mobility and her neurological assessment indicated lower body weakness and left hand weakness.</p> <p>The undated fall risk assessment, provided by the DON on 2/5/13 at 2:30 p.m., indicated Resident A was at risk for falls.</p> <p>The 1/17/13 Temporary Admission Care Plan, provided by the DON on 2/5/13 at 2:30 p.m., indicated Resident A was a "fall risk related to risk factors identified on fall risk assessment." An intervention was "Provide assistance for transfers, bed mobility."</p>		<p>place or what systemic changes will you make to ensure that the deficient practice does not recur? All CNAs will be re-educated on appropriate positioning and turning techniques, precautions to be taken with those residents with weakness related to CVAs, and complete a positioning skills validation by the SDC by 2/20/13. A positioning/fall prevention CQI audit rounding tool will be completed 3 x a week encompassing all shifts for 1 month, then once weekly for 5 months by a nurse manager or designee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? A positioning/fall prevention CQI audit rounding tool will be completed 3 x a week encompassing all shifts for 1 month, then once weekly for 5 months by a nurse manager or designee The positioning/fall; prevention CQI audit rounding tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of Compliance 2/20/13.</p>				

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	<p>During an interview with Resident A on 2/5/13 at 1:40 p.m., she indicated a couple weeks prior, a CNA (Certified Nursing Assistant) was providing incontinent care for her in her bed. She indicated the CNA was turning her when she rolled off the bed, hit her head on her oxygen tank, and landed on the floor. She stated, "I told her I couldn't use my left side. I told her not to turn me." She indicated the CNA was on the opposite side of the bed from which she rolled. At this time, Resident A was observed in her wheelchair next to the left side of her bed, the same side on which she indicated she landed on the floor after her fall. Her oxygen concentrator was observed behind her, against the wall next to the head of her bed.</p> <p>The 1/19/13, 8:58 a.m. nursing progress note indicated, "Res (resident) noted falling out of bed. CNA states while changing res turned res to right side and res was too close to that side of bed leaving res left side w/o (without) control d/t (due to) CVA (cerebral vascular accident) with left</p>						

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	<p>side weakness res and CNA states res hit head on 02 (oxygen) concentrator...."</p> <p>The 1/21/13, 11:59 a.m. IDT (Interdisciplinary Team) progress note indicated, "...resident was being turned in bed by staff and rolled out of bed, resident bumped head on 02 concentrator, ...IDT feels cause related resident unable to assist with positioning in bed."</p> <p>During an interview with the DON on 2/5/13 at 4:00 p.m. regarding whether he thought the CNA contributed to Resident A's fall, he indicated, "It's hard to say. She was giving care, so the CNA was a part of the incident. We knew she had left side weakness. We knew she was at risk." He also indicated the CNA was given verbal education on turning a resident after Resident A's fall, but had no documentation of this education.</p> <p>The CNA involved in Resident A's 1/19/13 fall was unavailable for interview.</p>						

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	3.1-45(a)(2)						